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market power? Is that what you're saying?
MR. SOBOL: Objection.
A. No. I just -- I made a comment about what generated market power on the part of physicians, and the --
Q. Well, why are payers willing to let physicians earn up to 30 percent on drugs in your view?
A. In my view, it reflects what Mr. -- what Mr. Young had stated: That in prior to 1992, going into 1992, Medicare essentially reimbursed on a cost basis, and the cost was assumed to be more or less AWP, and that -- and as -- as the transition went into more focus on reimbursement under Medicare, there was a realization that reimbursement at AWP or some percent -- and then the percentage off of AWP and the private third-party payers, that allowed the doctors to earn what was the retail margin, more or less.
So there is a small margin that the doctors were earning as part of their administering the drugs, and I don't think that

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was a -- they weren't thinking about market power at that point or -- whatever they -- the realization of the market power was on the part of the manufacturers in terms of increasing the spread.
Q. But that margin is 30 percent; right?
A. With the --
MR. SOBOL: Objection.
A. No.
Q. In other words, in your but-for world, assuming a payer understood what ASP was and sat down with a provider and negotiated a contract, that payer should be willing to reimburse that provider at a rate that is 30 percent above the ASP; correct?
MR. SOBOL: Objection.
A. When we look at the Medpac survey, we find that different payers have themselves different amounts of clout in the negotiations, such that they are willing to -- they agree to reimburse AWP less 15 percent, 85 percent of AWP, and some are up to AWP plus 10 percent. If we

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look at the Dyckman figure 13 -- oh, no, -- oh, yes, that is right.
So if I am on average, this average is about 97 percent of AWP, and so for the aggregate measure of what the payers are willing to -- have been reimbursing or the profits that are earned on aggregate by the providers, at some aggregate measure, it is 97 percent -- 95 -- 97.5 percent AWP less ASP, over ASP, so it is a little less than 30 percent.
Q. Well, let's take a contract where the reimbursement rate is AWP.
A. That's fine. Then we are at 30 percent.
Q. In that situation, you would agree with me that the provider is willing to -- I am sorry -- that the payer is willing to enable the provider to earn a profit of 30 percent over the acquisition cost of the drug; correct?
MR. SOBOL: Objection.
A. In that world, the provider is allowed to drive the speed limit.
Q. Right. And the payer is agreeing with

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the provider, basically it is okay with me if you earn 30 percent on these drugs; that's why I am setting the AWP -- I am sorry -- that is why I am setting the reimbursement rate at AWP; correct?
A. The -- that is assuming the provider knows -- the payer knows the ASP. The payer until 2005 did not.
Q. But I want you to --
A. But, you know, there is some -- the providers up until that point saw some of these anecdotal information, but that would have said to me prior to 2005 that the provider -- the payer thought, well, the guy is earning the retail margin plus some, so, you know, could be making 10 percent, 15 percent above ASP, 5 percent.
Q. Well, assume with me that the payer knew what the ASP was --
A. Okay.
Q. -- and the payer agreed to reimburse the provider at AWP. In that scenario, the payer would be agreeing that the provider could earn a margin of 30 percent; correct?

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A. In that -- in that example, the payer agrees to the upper bound of the expectations that I have found in the data that had been used for my -- for the liability yardstick in my December declaration.
Q. And that 30 percent would essentially reflect the providers' market power in that particular negotiation; correct?
A. No. I mean they are also negotiating the fees, so that there are other things being negotiated. Money being paid to the provider is not just the amount on the drugs. There is fees, and there is -- there is other things being negotiated.
Q. So you can't really analyze the impact of the spread in a situation like this without looking at all of the other aspects of the contractual relationship between the payer and the provider? Is that what you're saying?
A. No.
Q. What is your definition of market power?
A. Market power can -- the traditional

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textbook definition of market power in thinking about a monopolist is that, or a small group of producers, is that there is essentially enough control of production in that market that there is the power to raise price above cost, and that's a textbook definition of --
Q. And in the particular --
A. -- one of --
Q. -- example I just recited where the provider has been reimbursed at AWP, that provider has sufficient market power to raise the price to 30 percent above cost; correct?
MR. SOBOL: Objection to the form.
A. We've -- the -- we have already discussed -- I mean right now we're talking about a variety of different notions of market power. I mean there is -- I have given you the textbook example, but another notion of having power to influence the market or market power is to move market share, and that is something that is -- that is retained and that reflects the physician's position and the providers' position in the

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provider -- in the world of providers.
So that, that type of market power relative to the -- his clients, the doctors' clients, the patients, and what they are going to end up paying for, that -- that is a market power that -- it -- we're -- is a little bit off what you're trying to get at here. You are talking about the payers trying to pay them something or -- I'm not talking -- the market power I am talking about is not in negotiating with the payer right now. I am talking about the ability to move patients from one drug to another, and that power, and that right now is not -- that's - - we're not -- they're not -- that's not being -- I am not sitting down as a provider and negotiating with a payer just based on that notion.
Q. Are you saying that providers have no market power in their negotiations with payers?
A. I would say that there is some providers that have -- I would say that there is variation in that market power.
Q. In the situation where the provider is

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able to earn a profit of 30 percent over ASP, how much of that 30 percent is attributable to the providers' market power?
A. The revealed negotiations of the implications of market power and the ability in the negotiations to effectuate reimbursement and, therefore, demonstrate market power is shown in Exhibit 13 of the Dyckman report where the percentage off of AWP ranges from 85 to 115. So this is merely one measure of what the ability is of a provider to take advantage of whether it is a large oncology group or just a single practitioner. The service fees and other things are also part of that. So you are -- that question can't be answered only looking at drug costs.
Q. So but you are saying that some part of that 30 percent would be attributable to the provider's market power? You just haven't figured out what it is yet; correct?
MR. SOBOL: Objection.
A. It is -- the question is so -- I don't -

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- I don't understand what you mean by parsing that and attributing part of it. I -- I -- I guess I don't really understand what you're getting at.
Q. Is any part of it attributable to the provider's market power?
A. Well, one can certainly say that in a negotiation where there is some understanding of what acquisition costs are and that is -- there is asymmetric information. Up to 2005, apparently only the provider knew what the ASP was, except for anecdotal information in Barron's and reports here and there, but as providers sat down and negotiated with payers, they were able to extract -- they knew what their ASP was for all their drugs, and they were able -- some were able to say, look, I want to be reimbursed AWP plus 15 -- plus 15 percent. Well, they were in a stronger position to negotiate in that bilateral negotiation, and they revealed power.
Now that is not really the classic definition of market power, and I don't know really what you're getting at with market power

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and percentages of this related to that. We are talking about the ability in a negotiation to come up with some -- some relationship of what your reimbursement is going to be, period, and that is based on -- historically based on the providers knew what their ASPs were; Medicare and the payers did not. They came to understand what they were.
But this distribution here indicates the ability of payers -- of providers to say, "I want a higher -- no matter what my ASP is, I want more money to be reimbursed to me from you," and they get it, so that is power.
(Pointing to Exhibit Hartman 020.)
A. That's an ability to take advantage of the position, your market position, and increase your price.
Q. Have you considered whether some payers don't care about the cost of individual drugs to the provider? All they care about is the bottom-line profitability of the provider?
A. I would -- I haven't -- you know, I could speculate, but I haven't done any detailed

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analysis of that.
MR. EDWARDS: Time for a short break?
MR. SOBOL: Okay.
THE VIDEOGRAPHER: The time is 4:14. This is the end of cassette number 3. We are off the record.
(Recess taken at 4:14 p.m.)
(Recess ended at 4:28 p.m.)
THE VIDEOGRAPHER: The time is 4:28 p.m. This is the beginning of cassette number 4 in the deposition of Mr. Raymond Hartman. We are on the record.
BY MR. EDWARDS:
Q. Dr. Hartman, I want to turn to that portion of your report that deals with the damage yardstick for Medicare, and I guess in your supplemental report, it is the yardstick for liability and damages, and that is the yardstick that you have characterized as, I think, zero by statute in your previous testimony; is that correct?
A. I've -- I've used the shorthand that the

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spread would be zero in that case. That essentially that the re -- yes. That's -- yes.
Q. And the statute is what statute?
A. Well, it is an unfolding set of statutes and revisions that are laid out in footnote 13, which has the sources within the CFR regulations of what the reimbursement under Medicare would be, and for single-source and multi-source drugs, so it essentially is the basis for wherever I cite a spread or a calculation for damages, it is based on the Medicare statutes as they are summarized in footnote 13.
Q. For the period 1992 through 1997, are you talking about a statute or a regulation?
A. I'm -- it is my understanding it is a regulation. I -- not being a lawyer, I kind of think of them as the same, and actually, I almost thought -- I thought Judge Saras referred to them as statutory enablement, too.
Q. Are you familiar with the regulation?
A. You know, I have skimmed parts of it. I am familiar with these sections of it. I mean

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there is a lot of paper involved with every revision.
MR EDWARDS: What I want to do is mark as Exhibit Hartman 038 a copy of an excerpt of the regulation, which is 45 CFR -- no -- it is 42 CFR. I believe it is 405.
THE WITNESS: .517 maybe.
(Excerpt from Federal Register marked Exhibit Hartman 038 for identification.)
BY MR. EDWARDS:
Q. Which portion of the regulation do you rely on? And let me just say that we have provided a copy of the actual regulation as it appears in the Federal Register, but it is --
A. Blurry.
Q. -- hard to read, and there is a typed-up version attached to it.
A. I thought you just gave me -- I thought it was like the dribble glass. This is the dribble exhibit that I can't really read. I mean I am having trouble.
Q. Why don't you look at the last page of

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this document, Exhibit Hartman 038.
(Witness complying.)
A. Okay. And?
Q. There is a reference to Section 405.517. Is that the regulation that you rely on?
A. The last page of all of the typed pages or -- oh, I see here. Okay. 405.517?
(Pause.)
(The witness viewing Exhibit Hartman 038.)
A. That is correct. That is what is summarized in footnote 12 for reimbursement covering the period '92 through 1997.
Q. Now you admitted at your last deposition that you are not an expert on Medicare regulations and you don't have a law degree. Has that changed?
A. No.
Q. Are you expressing an expert opinion that it is zero by statute, or are you simply assuming that that will be proven by other means, and you are just running the numbers, assuming

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that proposition is established?
A. I would frame it -- I am -- I am -- maybe the answer is yes to that, but let me just see, make sure.
The statute is what it is, and it says how reimbursement should be paid under Medicare claims, and given that, that's my understanding of what the regulations are and how reimbursement should have been paid by Medicare, and that just -- that exists. I -- I then go and do analyses of thresholds of liability to see whether drugs are applicable to evaluating what the implications of this alternative reimbursement strategy -- reimbursement regulation is if the reimbursement was not at the acquisition cost.
Q. So you are offering an opinion on the proper interpretation of this regulation?
A. I am offering an interpretation on -- that is nothing more than my reading of what -- what you have in a box there about what -- what the reimbursement rate should be. That it is going to be, as I have stated in that footnote, payment

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for a drug is based on the lower of the estimated acquisition cost or the national average wholesale price of the drug. That -- and that's what it says here. And then for multi- source drugs, the payment is based on the lower of the estimated acquisition cost or the wholesale price for purposes -- for that period of time. It is defined as median price for all sources of the generic form of the drug, so.
Q. What is it that qualifies you to offer that opinion?
A. My ability to read.
Q. Nothing more?
A. That's right.
Q. So anybody could offer this opinion?
A. If -- I am assuming this is how reimbursement was to be made, and because I am reading it here in the regulations, and that's -- that's as far as my opinion goes.
Q. This opinion doesn't depend on your expertise as an economist; correct?
A. That's correct.

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Q. You did not take any courses on statutory interpretation in graduate school; correct?
A. No.
Q. Now this regulation actually says that estimated acquisition cost and average wholesale price are two different things, doesn't it?
A. I'm sorry. Could you say that again? I was -- it -- it?
Q. This regulation says, "Payment for a drug described in paragraph A of this section is based on the lower of the estimated acquisition cost or" -- and it uses the word "or" -- "the national average wholesale price of the drug." Correct?
A. That's correct.
Q. And the use of "or" in that context suggests that estimated acquisition cost and AWP are two different things; correct?
A. They -- they could -- they could be equal to the same thing, but it is not -- but it doesn't -- it says "or," so it is the lesser of.

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Q. The lesser of, so it is two different things; correct?
A. One or the other. Yes. Two different measures.
Q. And as far as you know, Medicare understood that estimated acquisition cost and AWP were two different things; correct?
A. That's my understanding.
Q. The regulation goes on to say that "The estimated acquisition cost is determined based on surveys of the actual invoice prices paid for the drug."
Do you know whether those surveys were ever conducted?
A. It's my understanding they were not.
Q. So the estimated acquisition cost part of this regulation was never implemented; correct?
A. Those surveys were not -- were not done.
Q. So you are basing your opinion that the proper reimbursement rate under Medicare is zero by statute on a provision of a regulation that was never implemented?

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A. Well, it's -- the -- the reimbursement rate is not zero. The spread, the measured spread, would be zero. The -- essentially what the -- what this is saying is, "Look, if you are going to reimburse, you are going to reimburse at AWP or the estimated acquisition cost," and the estimated acquisition cost was out there. It is just the surveys weren't done to inform Medicare what it was.
Q. But your opinion that it is zero by statute is based on the estimated acquisition cost part of this regulation; correct?
A. My calculation of damages, if a -- in my December report, if a drug exceeds a threshold of liability, of the 30 percent, then there is a calculation of what are the implications of the deviation of a reimbursement being at AWP when by statute it should have been by -- at the estimated acquisition cost.
Q. You are assuming that estimated acquisition cost, if it had been implemented, would have yielded a spread of zero; correct?

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A. The --
Q. In other words, EAC would have equalled ASP as defined in your December 15th report?
A. EAC would be equal to the estimated -- the -- it is also referred to as the average acquisition cost in some -- in some of the descriptions of this.
But the average acquisition cost is the average sales price to the set of providers that we're talking about, and to the extent that the AWP exceeds that average sale price, under this payment regulation I calculate the extent of that spread as a measure to which the reimbursement was greater than the estimated acquisition cost.
Q. Well, Medicare could not have intended that the AWP prong of this regulation would have yielded a spread of zero because Medicare understood that AWP exceeded estimated acquisition cost in many cases by a considerable amount; correct?
MR. SOBOL: Objection to form.
A. I was not asked to do an analysis of

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those issues. The analysis I was asked to do, which I think I have laid out pretty clearly, is that to identify what -- what the expected relationship between AWP and the various transaction costs, most importantly ASP was, to set a bound for that, and having done so, go back to the Medicare statute and see if there are implications therefrom for those drugs where liability was -- that liability threshold was exceeded, what the implications were under the statute for payment, and that's what I have done. I haven't been asked -- I haven't been asked to analyze what -- how Medicare thought about that or anything else.

Q. Well, let me ask you this. If the regulation had simply said payment for a drug will be at AWP, would you have construed that to mean zero by statute?

MR. SOBOL: Objection.

A. Zero by statute? That the spread would be zero? I don't -- I don't understand. What is zero? Are we talking about --

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Q. Well, that is your language.

A. Well, are we talking about -- but we are talking about -- you are mixing the measure of a spread. If -- if we want to use my language, let's refer to the paragraph in which we're using it, because there is some complexity of going between the spreads, and a zero spread, and then the damage calculation that is a difference between an AWP and an ASP, and I think -- let me just draw your attention to it. It may make it easier.

(Pause.)

(The witness viewing Exhibit Hartman 023.)

A. That is in paragraph 63, this is where there is this notion of the zero spread. I will let you get there.

Q. I'm there.

A. Okay. Here is the description, because much of the language was related to measured spreads and a yardstick spread for liability, I first put in the damage language and calculations

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relative to what the implications were for the spread, and there is, for the single-source drugs, you are seeing '91 to 2003 that spread of zero.

I think it is a little clearer to go from -- to make this a little more straightforward, to go right to paragraph 64, the next one, where that zero is translated into what the real calculation is, because I think that will make it clearer what we're talking about here.

When the spread is zero, it means that anything where the AWP exceeds the ASP is a measure of damages, and then for '98 through 2003, it is 95 percent of AWP. So this will allow us to talk about what I mean by a zero spread and what the implications are for the calculations of damages, because in 64 is the way it is done.

So if you could rephrase -- I mean all of the things we have been saying was the estimated acquisition cost is the ASP. That is their AWP.

You had a hypothetical now about suppose they charged AWP or -- if you could rephrase that.

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Q. Yes. My question to you, Dr. Hartman, was whether if the regulation had simply said reimbursement will be at AWP, you would have concluded that the proper reimbursement rate was a zero spread by statute.

A. No.

Q. Okay.

MR. EDWARDS: Now I want to mark as Exhibit Hartman 039 a copy of a letter from Frank Camozzi, chief of the technical issue section of Medicare, to S. Stewart dated November 4, 1994, the Bates stamps are HHC 015-1693 to 94.

(Two-page letter dated November 4, 1994, to Ms. S. Stewart from Mr. Camozzi marked Exhibit Hartman 039 for identification.)

(Handing Exhibit Hartman 039 to the witness.)

BY MR. EDWARDS:

Q. Have you ever seen this document before?

A. No. DMSO? Wow.

Q. Are you aware that the government has made a significant production to the defendants in

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this case of documents relating to this issue?
A. Which issue are we talking about here? Do you mean the issue of --
Q. The issue of reimbursement under Medicare.
A. I've had my staff review and told them to review a variety of documents that fit within certain guidelines. I don't remember them putting -- bringing this to my attention or some of the other -- I mean I don't know how substantial the correspondence is, but I have not seen this.
Q. In the third paragraph of this letter, Mr. Camozzi says, quote, "However, the Healthcare Financing Administration, HCFA, has not yet implemented the estimated acquisition cost portion of this regulation or provided carriers with specific instructions on how to execute this segment of the drug payment policy."
Is that consistent with your understanding?
A. As I say, my understanding was that the surveys had not been done and the information had

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not been gathered, and if this is -- you know, if this is an offshoot of that, you know, I didn't -- I didn't know this -- this followed.
Q. Well, as of November 4, 1994, at least, the EAC prong of the regulation on which you rely had not been implemented; correct?
A. I am not sufficiently schooled in the administrative law or whatever to make -- to make any judgment from this letter one way or the other. I mean that's something for a lawyer to conclude.
Q. Do you know whether it had been implemented as of 1995 or 1996?
A. Are we talking about have the surveys been implemented, or are you talking about now this acquisition portion of the regulation?
Q. I am talking about the estimated acquisition cost portion of the regulation.
A. As I say, I've -- my understanding of the regulations are as put forward in the footnote we've been talking about. I had understood that the surveys had not been done, and that's all I

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understood, and what that meant in terms of legal implications, I do not know.
Q. So you didn't know that the estimated acquisition cost portion of the regulation had not been implemented?
A. I, you know, judging from this, I don't know one way or the other. I don't know what that means, "has not been implemented."
Q. Well, would it be fair to say that "has not been implemented" means has not been implemented?
A. Well, it would be fair to say the following. That since no one had done any surveys that I know of, no one knew what an estimated acquisition cost was, so it -- whether -- so there -- so that it would be impossible to implement this particular section of CFR from '92 to '97 in my footnote.
Q. Well, you said you base your interpretation of the regulation on your understanding of the English language. Is it consistent with your understanding of the English

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language that the words "has not been implemented" in this document means exactly what they say, has not been implemented?
A. Well, I see -- I see this in re: HCPCS code J 1212, injection of DMSO, and so I don't know whether this is -- I don't -- this does not seem to me to be a broad-based policy letter. Maybe it is. I just -- I don't know. I can't tell from this.
I don't -- if this were in re, you know, the implications of estimating -- of estimated acquisition cost portion, then I -- then I would see a broader application. I don't know. It does say that. But how broad -- broadly that went through, all drug reimbursement -- I know there were -- estimated acquisition costs were out there. They could -- I mean there were acquisition costs. One could estimate them. They weren't -- Medicare wasn't doing it. So it be would very hard to implement this calculation that I have gone ahead and implemented.
Q. I take it you have never talked to

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anybody who worked at HCFA during this time period in order to determine whether your interpretation of the regulation is correct?

A. I have never talked to anyone at HCFA about whether because the surveys had not been done that essentially this phrasing is such that -- - that they -- that there was no estimated acquisition cost. I would have to say that from '98 through 2003 they went to the lower of the actual bill -- actual charge, which by its nature is an estimated acquisition cost, and there is discussion in footnote 14 from CMS of what that means, and so there was -- there was -- you know, whether this, you know, average worked and how far it went, there is still clearly some reliance on acquisition costs, and as it was stated in the '98 through 2003 regulation.

So I haven't done -- I have taken -- I have taken the CFR as it reads and assumed that that was the guiding -- that was what was guiding reimbursement.

Q. Well, you just stated that the law was

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changed in 1997 or 1998 to indicate that reimbursement would be based on the lower of the billed charge or 95 percent of AWP?

A. The actual charge or 95 percent of the national AWP.

Q. And it is your testimony that the words "actual charge" in that context refer to the amount that the physician paid for the drug?

A. Well, it is not just my testimony. It is the testimony of CMS. In footnote 14 I cite Thomas Scully talking about how these types of drugs would be reimbursed, "and by law, we generally pay for these drugs based on the actual charge or 95 percent of the AWP, whichever is lower," which says to me it is -- the bill charges the acquisition, whichever is lower, and Mr. Young clarifies that further in the same footnote where he says in his paragraph 170, "From 1992 to date, moreover, reimbursement under Medicare Part B has generally been made at the lower of the billed charge amount or AWP through '97 or 95 percent of AWP after '97. The carriers may reimburse at less

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than the AWP base rates where, for instance, the physician's bill charges are less."

That is acquisition cost.

Now I mean maybe Mr. Young is wrong, and maybe Mr. Scully is wrong, but I have -- this entire notion of acquisition, bill charged, it has been in that vein that I have seen it throughout the Medicare regulations.

Q. How do you know that the phrase "billed charge" does not refer to the charge that the physician puts on the Medicare claim as opposed to the price that the physician pays for the drug?

A. It is my reading of these particular citations and other materials which I can't -- I can't recall right now. I can try and look -- look at what those cites are.

Q. Are you prepared to stake your reputation on that reading?

MR. SOBOL: Objection.

A. Stake my reputation?

Q. Your reading could be wrong; correct?

A. My reputation as a reader or as what? I

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am not -- I am not an expert in -- we know I am not an expert in Medicare regulations, and I am reading what some of your own experts have said, and I'm reading what some of the CMS representatives and -- let's see what it -- what it is -- the CMS administrator has said, and I am interpreting it in that way, and that's as --

Q. Well, what Mr. Scully and Mr. Young said is not inconsistent with the interpretation that "actual charge" refers to the charge that the physician puts on the Medicare claim form as opposed to the price that the physician pays for the drug; correct?

A. It is my understanding that they were to be one and the same.

MR. EDWARDS: What I am going to do is mark as Deposition Exhibit Hartman 040 a copy of 42 CFR 405.517 revised as of October 1, 1999.

(42 CFR 405.517 marked Exhibit Hartman 040 for identification.)

MR KAUFMAN: Excuse me, Steve. Is this number Exhibit Hartman 040?

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THE REPORTER: Exhibit Hartman 040.
(Handing Exhibit Hartman 040 to the witness.)
BY MR. EDWARDS:
Q. Have you seen Exhibit Hartman 040 before?
A. I think I have.
Q. You have actually looked at the regulation?
A. Oh, yes. I have had copies of each of these, the subsections. The boxed -- the boxed portions, I have had my staff pull out the specific wording that was applicable here, and at times, I have looked at it more broadly, but.
Q. So let me direct your attention to subsection B, which says "Methodology. Payment for a drug or biological described in paragraph A of this section is based on the lower of the actual charge on the Medicare claim for benefits or 95 percent of the national average wholesale price of the drug or biological."
Doesn't this demonstrate conclusively

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that your interpretation of the statute is wrong?
MR. SOBOL: Objection.
A. No.
MR. SOBOL: Before we go ahead, I know it is five o'clock.
Q. Doesn't this demonstrate conclusively that the statute --
MR. SOBOL: Hold on a second. Relax.
MR. EDWARDS: Excuse me?
MR. SOBOL: I know it is five o'clock. Do you want to finish your questions on this document?
MR. EDWARDS: Yes.
MR. SOBOL: Okay.
BY MR. EDWARDS:
Q. Doesn't this demonstrate conclusively that the words "actual charge" was -- were designed to reflect the charge that the physician put on the claim for benefits as opposed to the amount that the physician was charged by the manufacturer?
A. The particular sentence that you are

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pointing to appears verbatim in my footnote 13 under the guiding regulations for 1998 through 2003, so it is -- it is clear that I have read this. It is clear that I have taken this into account.
I have looked at the, as I said, said under footnote 14, additional testimony, and when I see here that the defendants' expert Steven Young has said that reimbursement under Medicare Part B is generally made at the lower of the billed charged amount, and that's what I am taking to be the amount charged on the Medicare claim --
Q. But billed by whom?
A. I am taking the billed charge on the part of the physician to be the same as the billed amount to the physician.
Q. Where does it say that? Where does it say that the charge that the physician puts on the Medicare claim form has to be the same as the price that the physician paid to the manufacturer?
A. I have told you that this is based on my broad -- broader reading of the documents in this

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matter, conversions with our affiliates at the Harvard School of Public Health regarding Medicare types of reimbursement, and it is based on that broad set of evidence.
Q. Did you read the legislative history of the Balanced Budget Act in 1997 which gave rise to this change in the Medicare reimbursement formula?
MR. SOBOL: Objection to the form.
A. It is my recollection I have read portions of that, but I -- I -- I -- it's -- I'm not certain.
Q. And are you aware of the fact that the Clinton administration proposed to Congress that reimbursement be based on the estimated acquisition cost of the physician and Congress rejected that?
MR. SOBOL: Objection.
A. I -- I am aware that there was -- there was much disagreement among various stakeholders in how reimbursement rates should be paid and calculated, and we have been talking about it all day.

Q. Are you aware of the fact that Congress rejected EAC as a basis for reimbursement in the Balanced Budget Act of 1997?

MR. SOBOL: Objection to the form. You may answer.

A. I think I have cited -- I know that Mr. Young has talked about that, and -- and so I -- I am generally aware of -- that there has been that debate and certain proposals have been rejected.

Q. And are you aware that that specific proposal was rejected?

MR. SOBOL: Objection to the form.

A. I'm not aware of the specificity of individual proposals being either rejected or accepted.

MR. EDWARDS: At this point, I would move on to some additional documents, Tom.

MR. SOBOL: Let's suspend for the day and reconvene tomorrow morning at 9:30, which is early for Mr. Hartman. That's why we're not starting earlier.

MR. EDWARDS: He will be here at eight

o'clock.

THE WITNESS: That is why I cannot take breaks.

MR. KAUFMAN: He is superman. He doesn't take breaks.

MR. SOBOL: Because he is late to work every day.

THE VIDEOGRAPHER: The time is 5:08. The deposition is suspended. This is the end of cassette 4. We are off the record.

(Whereupon, at 5:08 p.m., the deposition was adjourned.)

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RAYMOND S. HARTMAN, Ph.D.

Subscribed and sworn to and before me this _____ day of _____, 20____.

_____

Notary Public

CERTIFICATE

Commonwealth of Massachusetts

Plymouth, ss.

I, Judith McGovern Williams, a Registered Professional Reporter and Notary Public in and for the Commonwealth of Massachusetts, do hereby certify:

That RAYMOND S. HARTMAN, PH.D., the witness whose deposition is hereinbefore set forth, was duly sworn by me and that such deposition is a true record of the testimony given by the said witness.

IN WITNESS WHEREOF, I have hereunto set my hand this _____ day of _____, 2006.

_____

Judith McGovern Williams
Registered Professional Reporter
Certified Realtime Reporter
Certified LiveNote Reporter
Certified Shorthand Reporter No. 130993
My Commission expires:
April 2, 2010

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market power? Is that what you're saying?
MR. SOBOL: Objection.
A. No. I just -- I made a comment about what generated market power on the part of physicians, and the --
Q. Well, why are payers willing to let physicians earn up to 30 percent on drugs in your view?
A. In my view, it reflects what Mr. -- what Mr. Young had stated: That in prior to 1992, going into 1992, Medicare essentially reimbursed on a cost basis, and the cost was assumed to be more or less AWP, and that -- and as -- as the transition went into more focus on reimbursement under Medicare, there was a realization that reimbursement at AWP or some percent -- and then the percentage off of AWP and the private third-party payers, that allowed the doctors to earn what was the retail margin, more or less.
So there is a small margin that the doctors were earning as part of their administering the drugs, and I don't think that

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was a -- they weren't thinking about market power at that point or -- whatever they -- the realization of the market power was on the part of the manufacturers in terms of increasing the spread.
Q. But that margin is 30 percent; right?
A. With the --
MR. SOBOL: Objection.
A. No.
Q. In other words, in your but-for world, assuming a payer understood what ASP was and sat down with a provider and negotiated a contract, that payer should be willing to reimburse that provider at a rate that is 30 percent above the ASP; correct?
MR. SOBOL: Objection.
A. When we look at the Medpac survey, we find that different payers have themselves different amounts of clout in the negotiations, such that they are willing to -- they agree to reimburse AWP less 15 percent, 85 percent of AWP, and some are up to AWP plus 10 percent. If we

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look at the Dyckman figure 13 -- oh, no, -- oh, yes, that is right.
So if I am on average, this average is about 97 percent of AWP, and so for the aggregate measure of what the payers are willing to -- have been reimbursing or the profits that are earned on aggregate by the providers, at some aggregate measure, it is 97 percent -- 95 -- 97.5 percent AWP less ASP, over ASP, so it is a little less than 30 percent.
Q. Well, let's take a contract where the reimbursement rate is AWP.
A. That's fine. Then we are at 30 percent.
Q. In that situation, you would agree with me that the provider is willing to -- I am sorry -- that the payer is willing to enable the provider to earn a profit of 30 percent over the acquisition cost of the drug; correct?
MR. SOBOL: Objection.
A. In that world, the provider is allowed to drive the speed limit.
Q. Right. And the payer is agreeing with

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the provider, basically it is okay with me if you earn 30 percent on these drugs; that's why I am setting the AWP -- I am sorry -- that is why I am setting the reimbursement rate at AWP; correct?
A. The -- that is assuming the provider knows -- the payer knows the ASP. The payer until 2005 did not.
Q. But I want you to --
A. But, you know, there is some -- the providers up until that point saw some of these anecdotal information, but that would have said to me prior to 2005 that the provider -- the payer thought, well, the guy is earning the retail margin plus some, so, you know, could be making 10 percent, 15 percent above ASP, 5 percent.
Q. Well, assume with me that the payer knew what the ASP was --
A. Okay.
Q. -- and the payer agreed to reimburse the provider at AWP. In that scenario, the payer would be agreeing that the provider could earn a margin of 30 percent; correct?

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A. In that -- in that example, the payer agrees to the upper bound of the expectations that I have found in the data that had been used for my -- for the liability yardstick in my December declaration.
Q. And that 30 percent would essentially reflect the providers' market power in that particular negotiation; correct?
A. No. I mean they are also negotiating the fees, so that there are other things being negotiated. Money being paid to the provider is not just the amount on the drugs. There is fees, and there is -- there is other things being negotiated.
Q. So you can't really analyze the impact of the spread in a situation like this without looking at all of the other aspects of the contractual relationship between the payer and the provider? Is that what you're saying?
A. No.
Q. What is your definition of market power?
A. Market power can -- the traditional

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textbook definition of market power in thinking about a monopolist is that, or a small group of producers, is that there is essentially enough control of production in that market that there is the power to raise price above cost, and that's a textbook definition of --
Q. And in the particular --
A. -- one of --
Q. -- example I just recited where the provider has been reimbursed at AWP, that provider has sufficient market power to raise the price to 30 percent above cost; correct?
MR. SOBOL: Objection to the form.
A. We've -- the -- we have already discussed -- I mean right now we're talking about a variety of different notions of market power. I mean there is -- I have given you the textbook example, but another notion of having power to influence the market or market power is to move market share, and that is something that is -- that is retained and that reflects the physician's position and the providers' position in the

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provider -- in the world of providers.
So that, that type of market power relative to the -- his clients, the doctors' clients, the patients, and what they are going to end up paying for, that -- that is a market power that -- it -- we're -- is a little bit off what you're trying to get at here. You are talking about the payers trying to pay them something or -- I'm not talking -- the market power I am talking about is not in negotiating with the payer right now. I am talking about the ability to move patients from one drug to another, and that power, and that right now is not -- that's - - we're not -- they're not -- that's not being -- I am not sitting down as a provider and negotiating with a payer just based on that notion.
Q. Are you saying that providers have no market power in their negotiations with payers?
A. I would say that there is some providers that have -- I would say that there is variation in that market power.
Q. In the situation where the provider is

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able to earn a profit of 30 percent over ASP, how much of that 30 percent is attributable to the providers' market power?
A. The revealed negotiations of the implications of market power and the ability in the negotiations to effectuate reimbursement and, therefore, demonstrate market power is shown in Exhibit 13 of the Dyckman report where the percentage off of AWP ranges from 85 to 115. So this is merely one measure of what the ability is of a provider to take advantage of whether it is a large oncology group or just a single practitioner. The service fees and other things are also part of that. So you are -- that question can't be answered only looking at drug costs.
Q. So but you are saying that some part of that 30 percent would be attributable to the provider's market power? You just haven't figured out what it is yet; correct?
MR. SOBOL: Objection.
A. It is -- the question is so -- I don't -

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- I don't understand what you mean by parsing that and attributing part of it. I -- I -- I guess I don't really understand what you're getting at.

Q. Is any part of it attributable to the provider's market power?

A. Well, one can certainly say that in a negotiation where there is some understanding of what acquisition costs are and that is -- there is asymmetric information. Up to 2005, apparently only the provider knew what the ASP was, except for anecdotal information in Barron's and reports here and there, but as providers sat down and negotiated with payers, they were able to extract -- they knew what their ASP was for all their drugs, and they were able -- some were able to say, look, I want to be reimbursed AWP plus 15 -- plus 15 percent. Well, they were in a stronger position to negotiate in that bilateral negotiation, and they revealed power.

Now that is not really the classic definition of market power, and I don't know really what you're getting at with market power

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and percentages of this related to that. We are talking about the ability in a negotiation to come up with some -- some relationship of what your reimbursement is going to be, period, and that is based on -- historically based on the providers knew what their ASPs were; Medicare and the payers did not. They came to understand what they were.

But this distribution here indicates the ability of payers -- of providers to say, "I want a higher -- no matter what my ASP is, I want more money to be reimbursed to me from you," and they get it, so that is power.

(Pointing to Exhibit Hartman 020.)

A. That's an ability to take advantage of the position, your market position, and increase your price.

Q. Have you considered whether some payers don't care about the cost of individual drugs to the provider? All they care about is the bottom-line profitability of the provider?

A. I would -- I haven't -- you know, I could speculate, but I haven't done any detailed

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analysis of that.

MR. EDWARDS: Time for a short break?

MR. SOBOL: Okay.

THE VIDEOGRAPHER: The time is 4:14. This is the end of cassette number 3. We are off the record.

(Recess taken at 4:14 p.m.)

(Recess ended at 4:28 p.m.)

THE VIDEOGRAPHER: The time is 4:28 p.m. This is the beginning of cassette number 4 in the deposition of Mr. Raymond Hartman. We are on the record.

BY MR. EDWARDS:

Q. Dr. Hartman, I want to turn to that portion of your report that deals with the damage yardstick for Medicare, and I guess in your supplemental report, it is the yardstick for liability and damages, and that is the yardstick that you have characterized as, I think, zero by statute in your previous testimony; is that correct?

A. I've -- I've used the shorthand that the

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spread would be zero in that case. That essentially that the re -- yes. That's -- yes.

Q. And the statute is what statute?

A. Well, it is an unfolding set of statutes and revisions that are laid out in footnote 13, which has the sources within the CFR regulations of what the reimbursement under Medicare would be, and for single-source and multi-source drugs, so it essentially is the basis for wherever I cite a spread or a calculation for damages, it is based on the Medicare statutes as they are summarized in footnote 13.

Q. For the period 1992 through 1997, are you talking about a statute or a regulation?

A. I'm -- it is my understanding it is a regulation. I -- not being a lawyer, I kind of think of them as the same, and actually, I almost thought -- I thought Judge Saras referred to them as statutory enablement, too.

Q. Are you familiar with the regulation?

A. You know, I have skimmed parts of it. I am familiar with these sections of it. I mean

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there is a lot of paper involved with every revision.
MR EDWARDS: What I want to do is mark as Exhibit Hartman 038 a copy of an excerpt of the regulation, which is 45 CFR -- no -- it is 42 CFR. I believe it is 405.
THE WITNESS: .517 maybe.
(Excerpt from Federal Register marked Exhibit Hartman 038 for identification.)
BY MR. EDWARDS:
Q. Which portion of the regulation do you rely on? And let me just say that we have provided a copy of the actual regulation as it appears in the Federal Register, but it is --
A. Blurry.
Q. -- hard to read, and there is a typed-up version attached to it.
A. I thought you just gave me -- I thought it was like the dribble glass. This is the dribble exhibit that I can't really read. I mean I am having trouble.
Q. Why don't you look at the last page of

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this document, Exhibit Hartman 038.
(Witness complying.)
A. Okay. And?
Q. There is a reference to Section 405.517. Is that the regulation that you rely on?
A. The last page of all of the typed pages or -- oh, I see here. Okay. 405.517?
(Pause.)
(The witness viewing Exhibit Hartman 038.)
A. That is correct. That is what is summarized in footnote 12 for reimbursement covering the period '92 through 1997.
Q. Now you admitted at your last deposition that you are not an expert on Medicare regulations and you don't have a law degree. Has that changed?
A. No.
Q. Are you expressing an expert opinion that it is zero by statute, or are you simply assuming that that will be proven by other means, and you are just running the numbers, assuming

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that proposition is established?
A. I would frame it -- I am -- I am -- maybe the answer is yes to that, but let me just see, make sure.
The statute is what it is, and it says how reimbursement should be paid under Medicare claims, and given that, that's my understanding of what the regulations are and how reimbursement should have been paid by Medicare, and that just -- that exists. I -- I then go and do analyses of thresholds of liability to see whether drugs are applicable to evaluating what the implications of this alternative reimbursement strategy -- reimbursement regulation is if the reimbursement was not at the acquisition cost.
Q. So you are offering an opinion on the proper interpretation of this regulation?
A. I am offering an interpretation on -- that is nothing more than my reading of what -- what you have in a box there about what -- what the reimbursement rate should be. That it is going to be, as I have stated in that footnote, payment

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for a drug is based on the lower of the estimated acquisition cost or the national average wholesale price of the drug. That -- and that's what it says here. And then for multi- source drugs, the payment is based on the lower of the estimated acquisition cost or the wholesale price for purposes -- for that period of time. It is defined as median price for all sources of the generic form of the drug, so.
Q. What is it that qualifies you to offer that opinion?
A. My ability to read.
Q. Nothing more?
A. That's right.
Q. So anybody could offer this opinion?
A. If -- I am assuming this is how reimbursement was to be made, and because I am reading it here in the regulations, and that's -- that's as far as my opinion goes.
Q. This opinion doesn't depend on your expertise as an economist; correct?
A. That's correct.

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Q. You did not take any courses on statutory interpretation in graduate school; correct?
A. No.
Q. Now this regulation actually says that estimated acquisition cost and average wholesale price are two different things, doesn't it?
A. I'm sorry. Could you say that again? I was -- it -- it?
Q. This regulation says, "Payment for a drug described in paragraph A of this section is based on the lower of the estimated acquisition cost or" -- and it uses the word "or" -- "the national average wholesale price of the drug." Correct?
A. That's correct.
Q. And the use of "or" in that context suggests that estimated acquisition cost and AWP are two different things; correct?
A. They -- they could -- they could be equal to the same thing, but it is not -- but it doesn't -- it says "or," so it is the lesser of.

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Q. The lesser of, so it is two different things; correct?
A. One or the other. Yes. Two different measures.
Q. And as far as you know, Medicare understood that estimated acquisition cost and AWP were two different things; correct?
A. That's my understanding.
Q. The regulation goes on to say that "The estimated acquisition cost is determined based on surveys of the actual invoice prices paid for the drug."
Do you know whether those surveys were ever conducted?
A. It's my understanding they were not.
Q. So the estimated acquisition cost part of this regulation was never implemented; correct?
A. Those surveys were not -- were not done.
Q. So you are basing your opinion that the proper reimbursement rate under Medicare is zero by statute on a provision of a regulation that was never implemented?

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A. Well, it's -- the -- the reimbursement rate is not zero. The spread, the measured spread, would be zero. The -- essentially what the -- what this is saying is, "Look, if you are going to reimburse, you are going to reimburse at AWP or the estimated acquisition cost," and the estimated acquisition cost was out there. It is just the surveys weren't done to inform Medicare what it was.
Q. But your opinion that it is zero by statute is based on the estimated acquisition cost part of this regulation; correct?
A. My calculation of damages, if a -- in my December report, if a drug exceeds a threshold of liability, of the 30 percent, then there is a calculation of what are the implications of the deviation of a reimbursement being at AWP when by statute it should have been by -- at the estimated acquisition cost.
Q. You are assuming that estimated acquisition cost, if it had been implemented, would have yielded a spread of zero; correct?

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A. The --
Q. In other words, EAC would have equalled ASP as defined in your December 15th report?
A. EAC would be equal to the estimated -- the -- it is also referred to as the average acquisition cost in some -- in some of the descriptions of this.
But the average acquisition cost is the average sales price to the set of providers that we're talking about, and to the extent that the AWP exceeds that average sale price, under this payment regulation I calculate the extent of that spread as a measure to which the reimbursement was greater than the estimated acquisition cost.
Q. Well, Medicare could not have intended that the AWP prong of this regulation would have yielded a spread of zero because Medicare understood that AWP exceeded estimated acquisition cost in many cases by a considerable amount; correct?
MR. SOBOL: Objection to form.
A. I was not asked to do an analysis of

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those issues. The analysis I was asked to do, which I think I have laid out pretty clearly, is that to identify what -- what the expected relationship between AWP and the various transaction costs, most importantly ASP was, to set a bound for that, and having done so, go back to the Medicare statute and see if there are implications therefrom for those drugs where liability was -- that liability threshold was exceeded, what the implications were under the statute for payment, and that's what I have done. I haven't been asked -- I haven't been asked to analyze what -- how Medicare thought about that or anything else.

Q. Well, let me ask you this. If the regulation had simply said payment for a drug will be at AWP, would you have construed that to mean zero by statute?

MR. SOBOL: Objection.

A. Zero by statute? That the spread would be zero? I don't -- I don't understand. What is zero? Are we talking about --

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Q. Well, that is your language.

A. Well, are we talking about -- but we are talking about -- you are mixing the measure of a spread. If -- if we want to use my language, let's refer to the paragraph in which we're using it, because there is some complexity of going between the spreads, and a zero spread, and then the damage calculation that is a difference between an AWP and an ASP, and I think -- let me just draw your attention to it. It may make it easier.

(Pause.)

(The witness viewing Exhibit Hartman 023.)

A. That is in paragraph 63, this is where there is this notion of the zero spread. I will let you get there.

Q. I'm there.

A. Okay. Here is the description, because much of the language was related to measured spreads and a yardstick spread for liability, I first put in the damage language and calculations

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relative to what the implications were for the spread, and there is, for the single-source drugs, you are seeing '91 to 2003 that spread of zero.

I think it is a little clearer to go from -- to make this a little more straightforward, to go right to paragraph 64, the next one, where that zero is translated into what the real calculation is, because I think that will make it clearer what we're talking about here.

When the spread is zero, it means that anything where the AWP exceeds the ASP is a measure of damages, and then for '98 through 2003, it is 95 percent of AWP. So this will allow us to talk about what I mean by a zero spread and what the implications are for the calculations of damages, because in 64 is the way it is done.

So if you could rephrase -- I mean all of the things we have been saying was the estimated acquisition cost is the ASP. That is their AWP.

You had a hypothetical now about suppose they charged AWP or -- if you could rephrase that.

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Q. Yes. My question to you, Dr. Hartman, was whether if the regulation had simply said reimbursement will be at AWP, you would have concluded that the proper reimbursement rate was a zero spread by statute.

A. No.

Q. Okay.

MR. EDWARDS: Now I want to mark as Exhibit Hartman 039 a copy of a letter from Frank Camozzi, chief of the technical issue section of Medicare, to S. Stewart dated November 4, 1994, the Bates stamps are HHC 015-1693 to 94.

(Two-page letter dated November 4, 1994, to Ms. S. Stewart from Mr. Camozzi marked Exhibit Hartman 039 for identification.)

(Handing Exhibit Hartman 039 to the witness.)

BY MR. EDWARDS:

Q. Have you ever seen this document before?

A. No. DMSO? Wow.

Q. Are you aware that the government has made a significant production to the defendants in

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this case of documents relating to this issue?
A. Which issue are we talking about here? Do you mean the issue of --
Q. The issue of reimbursement under Medicare.
A. I've had my staff review and told them to review a variety of documents that fit within certain guidelines. I don't remember them putting -- bringing this to my attention or some of the other -- I mean I don't know how substantial the correspondence is, but I have not seen this.
Q. In the third paragraph of this letter, Mr. Camozzi says, quote, "However, the Healthcare Financing Administration, HCFA, has not yet implemented the estimated acquisition cost portion of this regulation or provided carriers with specific instructions on how to execute this segment of the drug payment policy."
Is that consistent with your understanding?
A. As I say, my understanding was that the surveys had not been done and the information had

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not been gathered, and if this is -- you know, if this is an offshoot of that, you know, I didn't -- I didn't know this -- this followed.
Q. Well, as of November 4, 1994, at least, the EAC prong of the regulation on which you rely had not been implemented; correct?
A. I am not sufficiently schooled in the administrative law or whatever to make -- to make any judgment from this letter one way or the other. I mean that's something for a lawyer to conclude.
Q. Do you know whether it had been implemented as of 1995 or 1996?
A. Are we talking about have the surveys been implemented, or are you talking about now this acquisition portion of the regulation?
Q. I am talking about the estimated acquisition cost portion of the regulation.
A. As I say, I've -- my understanding of the regulations are as put forward in the footnote we've been talking about. I had understood that the surveys had not been done, and that's all I

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understood, and what that meant in terms of legal implications, I do not know.
Q. So you didn't know that the estimated acquisition cost portion of the regulation had not been implemented?
A. I, you know, judging from this, I don't know one way or the other. I don't know what that means, "has not been implemented."
Q. Well, would it be fair to say that "has not been implemented" means has not been implemented?
A. Well, it would be fair to say the following. That since no one had done any surveys that I know of, no one knew what an estimated acquisition cost was, so it -- whether -- so there -- so that it would be impossible to implement this particular section of CFR from '92 to '97 in my footnote.
Q. Well, you said you base your interpretation of the regulation on your understanding of the English language. Is it consistent with your understanding of the English

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language that the words "has not been implemented" in this document means exactly what they say, has not been implemented?
A. Well, I see -- I see this in re: HCPCS code J 1212, injection of DMSO, and so I don't know whether this is -- I don't -- this does not seem to me to be a broad-based policy letter. Maybe it is. I just -- I don't know. I can't tell from this.
I don't -- if this were in re, you know, the implications of estimating -- of estimated acquisition cost portion, then I -- then I would see a broader application. I don't know. It does say that. But how broad -- broadly that went through, all drug reimbursement -- I know there were -- estimated acquisition costs were out there. They could -- I mean there were acquisition costs. One could estimate them. They weren't -- Medicare wasn't doing it. So it be would very hard to implement this calculation that I have gone ahead and implemented.
Q. I take it you have never talked to

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anybody who worked at HCFA during this time period in order to determine whether your interpretation of the regulation is correct?

A. I have never talked to anyone at HCFA about whether because the surveys had not been done that essentially this phrasing is such that -- - that they -- that there was no estimated acquisition cost. I would have to say that from '98 through 2003 they went to the lower of the actual bill -- actual charge, which by its nature is an estimated acquisition cost, and there is discussion in footnote 14 from CMS of what that means, and so there was -- there was -- you know, whether this, you know, average worked and how far it went, there is still clearly some reliance on acquisition costs, and as it was stated in the '98 through 2003 regulation.

So I haven't done -- I have taken -- I have taken the CFR as it reads and assumed that that was the guiding -- that was what was guiding reimbursement.

Q. Well, you just stated that the law was

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changed in 1997 or 1998 to indicate that reimbursement would be based on the lower of the billed charge or 95 percent of AWP?

A. The actual charge or 95 percent of the national AWP.

Q. And it is your testimony that the words "actual charge" in that context refer to the amount that the physician paid for the drug?

A. Well, it is not just my testimony. It is the testimony of CMS. In footnote 14 I cite Thomas Scully talking about how these types of drugs would be reimbursed, "and by law, we generally pay for these drugs based on the actual charge or 95 percent of the AWP, whichever is lower," which says to me it is -- the bill charges the acquisition, whichever is lower, and Mr. Young clarifies that further in the same footnote where he says in his paragraph 170, "From 1992 to date, moreover, reimbursement under Medicare Part B has generally been made at the lower of the billed charge amount or AWP through '97 or 95 percent of AWP after '97. The carriers may reimburse at less

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than the AWP base rates where, for instance, the physician's bill charges are less."

That is acquisition cost.

Now I mean maybe Mr. Young is wrong, and maybe Mr. Scully is wrong, but I have -- this entire notion of acquisition, bill charged, it has been in that vein that I have seen it throughout the Medicare regulations.

Q. How do you know that the phrase "billed charge" does not refer to the charge that the physician puts on the Medicare claim as opposed to the price that the physician pays for the drug?

A. It is my reading of these particular citations and other materials which I can't -- I can't recall right now. I can try and look -- look at what those cites are.

Q. Are you prepared to stake your reputation on that reading?

MR. SOBOL: Objection.

A. Stake my reputation?

Q. Your reading could be wrong; correct?

A. My reputation as a reader or as what? I

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am not -- I am not an expert in -- we know I am not an expert in Medicare regulations, and I am reading what some of your own experts have said, and I'm reading what some of the CMS representatives and -- let's see what it -- what it is -- the CMS administrator has said, and I am interpreting it in that way, and that's as --

Q. Well, what Mr. Scully and Mr. Young said is not inconsistent with the interpretation that "actual charge" refers to the charge that the physician puts on the Medicare claim form as opposed to the price that the physician pays for the drug; correct?

A. It is my understanding that they were to be one and the same.

MR. EDWARDS: What I am going to do is mark as Deposition Exhibit Hartman 040 a copy of 42 CFR 405.517 revised as of October 1, 1999.

(42 CFR 405.517 marked Exhibit Hartman 040 for identification.)

MR KAUFMAN: Excuse me, Steve. Is this number Exhibit Hartman 040?

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THE REPORTER: Exhibit Hartman 040.
(Handing Exhibit Hartman 040 to the witness.)
BY MR. EDWARDS:
Q. Have you seen Exhibit Hartman 040 before?
A. I think I have.
Q. You have actually looked at the regulation?
A. Oh, yes. I have had copies of each of these, the subsections. The boxed -- the boxed portions, I have had my staff pull out the specific wording that was applicable here, and at times, I have looked at it more broadly, but.
Q. So let me direct your attention to subsection B, which says "Methodology. Payment for a drug or biological described in paragraph A of this section is based on the lower of the actual charge on the Medicare claim for benefits or 95 percent of the national average wholesale price of the drug or biological."
Doesn't this demonstrate conclusively

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that your interpretation of the statute is wrong?
MR. SOBOL: Objection.
A. No.
MR. SOBOL: Before we go ahead, I know it is five o'clock.
Q. Doesn't this demonstrate conclusively that the statute --
MR. SOBOL: Hold on a second. Relax.
MR. EDWARDS: Excuse me?
MR. SOBOL: I know it is five o'clock. Do you want to finish your questions on this document?
MR. EDWARDS: Yes.
MR. SOBOL: Okay.
BY MR. EDWARDS:
Q. Doesn't this demonstrate conclusively that the words "actual charge" was -- were designed to reflect the charge that the physician put on the claim for benefits as opposed to the amount that the physician was charged by the manufacturer?
A. The particular sentence that you are

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pointing to appears verbatim in my footnote 13 under the guiding regulations for 1998 through 2003, so it is -- it is clear that I have read this. It is clear that I have taken this into account.
I have looked at the, as I said, said under footnote 14, additional testimony, and when I see here that the defendants' expert Steven Young has said that reimbursement under Medicare Part B is generally made at the lower of the billed charged amount, and that's what I am taking to be the amount charged on the Medicare claim --
Q. But billed by whom?
A. I am taking the billed charge on the part of the physician to be the same as the billed amount to the physician.
Q. Where does it say that? Where does it say that the charge that the physician puts on the Medicare claim form has to be the same as the price that the physician paid to the manufacturer?
A. I have told you that this is based on my broad -- broader reading of the documents in this

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matter, conversions with our affiliates at the Harvard School of Public Health regarding Medicare types of reimbursement, and it is based on that broad set of evidence.
Q. Did you read the legislative history of the Balanced Budget Act in 1997 which gave rise to this change in the Medicare reimbursement formula?
MR. SOBOL: Objection to the form.
A. It is my recollection I have read portions of that, but I -- I -- I -- it's -- I'm not certain.
Q. And are you aware of the fact that the Clinton administration proposed to Congress that reimbursement be based on the estimated acquisition cost of the physician and Congress rejected that?
MR. SOBOL: Objection.
A. I -- I am aware that there was -- there was much disagreement among various stakeholders in how reimbursement rates should be paid and calculated, and we have been talking about it all day.

Q. Are you aware of the fact that Congress rejected EAC as a basis for reimbursement in the Balanced Budget Act of 1997?

MR. SOBOL: Objection to the form. You may answer.

A. I think I have cited -- I know that Mr. Young has talked about that, and -- and so I -- I am generally aware of -- that there has been that debate and certain proposals have been rejected.

Q. And are you aware that that specific proposal was rejected?

MR. SOBOL: Objection to the form.

A. I'm not aware of the specificity of individual proposals being either rejected or accepted.

MR. EDWARDS: At this point, I would move on to some additional documents, Tom.

MR. SOBOL: Let's suspend for the day and reconvene tomorrow morning at 9:30, which is early for Mr. Hartman. That's why we're not starting earlier.

MR. EDWARDS: He will be here at eight

o'clock.

THE WITNESS: That is why I cannot take breaks.

MR. KAUFMAN: He is superman. He doesn't take breaks.

MR. SOBOL: Because he is late to work every day.

THE VIDEOGRAPHER: The time is 5:08. The deposition is suspended. This is the end of cassette 4. We are off the record.

(Whereupon, at 5:08 p.m., the deposition was adjourned.)

_____

RAYMOND S. HARTMAN, Ph.D.

Subscribed and sworn to and before me this _____ day of _____, 20____.

_____

Notary Public

CERTIFICATE

Commonwealth of Massachusetts

Plymouth, ss.

I, Judith McGovern Williams, a Registered Professional Reporter and Notary Public in and for the Commonwealth of Massachusetts, do hereby certify:

That RAYMOND S. HARTMAN, PH.D., the witness whose deposition is hereinbefore set forth, was duly sworn by me and that such deposition is a true record of the testimony given by the said witness.

IN WITNESS WHEREOF, I have hereunto set my hand this _____ day of _____, 2006.

_____

Judith McGovern Williams
Registered Professional Reporter
Certified Realtime Reporter
Certified LiveNote Reporter
Certified Shorthand Reporter No. 130993
My Commission expires:
April 2, 2010

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